Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 13-0547 BN
	)	
KENNETH POLLEY,	)	
	)	
Respondent.	)	

DECISION

Petitioner State Board of Nursing has cause to discipline Respondent Kenneth Polley's practical nurse license, based on incompetency, misconduct, and violation of professional trust or confidence.

Procedure

The Board filed its complaint on April 8, 2013. Mr. Polley was served on April 15, 2013 and filed his answer to the complaint on May 14, 2013.

We held a hearing on October 16, 2013. The Board was represented by its attorney, Ian Hauptli. Mr. Polley appeared in person and represented himself.

The Board filed its post-hearing brief on November 25, 2103. Mr. Polley was given until December 26, 2013 to file a post-hearing brief. He did not file one, so the case became ready for decision on that date.

Findings of Fact

1. Kenneth Polley is licensed by the State Board of Nursing as a licensed practical nurse (LPN) and his license has been valid and active at all times relevant to these proceedings.

2. Mr. Polley is a former police officer and was in the Marines. He was employed as an LPN at the Iron County Hospital in Pilot Knob, Missouri at all times relevant to these proceedings, and was working there on February 23, 2012.

3. On February 23, 2012, Mr. Polley was assisting a nurse, Sheila Kure, in the emergency room with her patient, E.C., at Ms. Kure's request. That shift, Mr. Polley was assigned to the medical floor of the hospital, which is located in the same general area as the emergency room. Staff such as Mr. Polley sometimes helped in the emergency room when it was particularly busy, as it was on February 23, 2012.[1]

4. E.C. had had stents placed in his heart at another hospital a week prior to February 23, 2012, and came in to the Iron County Hospital emergency room complaining of chest pain. He had taken nitroglycerin tablets prior to arriving, and been administered morphine in the emergency room, without relief. He wanted to be transferred to the hospital that had placed his stents, but that hospital did not have a bed immediately available. In the Iron County Hospital emergency room, he was demanding a particular pain medication at a particular dosage. E.C. was angry and began cursing at the nursing staff.

5. Mr. Polley went into E.C.'s room with the medication that the emergency room physician ordered, potassium, which is not pain medication, to administer to E.C. E.C. told

[1] We gather from the record that E.C. arrived in the emergency room shortly after midnight on February 23, 2012, and that the incident occurred around 3 a.m. Some of the documentation in the record makes reference to "February 22," 2012, which we consider a scrivener's error, attributable to the fact that the incident occurred so early in the morning of February 23.

Mr. Polley, "If it ain't for fuckin' pain, I don't fuckin' want it."[2] Mr. Polley left E.C.'s room without administering the medication.

6. Ms. Kure was tending to another of her patients who had appendicitis, and later asked Mr. Polley to go into E.C.'s room to run an E.K.G. on E.C. Mr. Polley said that when she asked him to do it, he "just kind of looked at her."[3] She asked him a second time. Mr. Polley "continued to look at her" and then asked Ms. Kure, "[A]re you asking me to go get it?"[4] She told him yes, because the patient could not be transferred without the test, "[s]o [Mr. Polley] went in to get it."[5]

7. When Mr. Polley entered E.C.'s room to run the test, E.C. was sitting in the hospital bed. The E.K.G. machine was at the foot of the bed, with about a foot of space between the bed and the machine. Mr. Polley went to the machine and looked down at it, with his back to E.C. E.C. said to Mr. Polley, "You need to get the fuck out of here."[6] Mr. Polley did not leave; did not explain to E.C. what he (Mr. Polley) needed to do or why; and did not attempt to de-escalate the situation. Instead, Mr. Polley looked over his shoulder and said to E.C., "I have a job to do, sir."[7]

8. E.C. came out of his bed and went toward Mr. Polley. E.C. bumped his chest into Mr. Polley's chest and pointed his finger in Mr. Polley's face.[8] Mr. Polley and E.C. shoved each other, and E.C. balled up his fists.[9] Mr. Polley, who is right handed, punched E.C. in the mouth with his left hand, knocking out E.C.'s tooth. Mr. Polley "then put [E.C.] in a position of

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2 Tr. 22, Testimony of Kenneth Polley.
3 *Id*.
4 *Id*.
5 *Id*.
6 *Id*. at 26.
7 *Id*.
8 Tr. 17, Testimony of Allison Ruck.
9 *Id*., and Petitioner's Exhibit A, p. 20 (labeled ""Exhibit 1, page 5"), Iron County Hospital's "Statement of Investigation," Interview of Kenneth Polley.

restraint."[10] At some point during the physical altercation, Mr. Polley shouted for someone to get E.C. off of him and to call the police.

9. Allison Ruck, a certified nurse assistant working at the hospital that day, was outside of, but near, the doorway of E.C.'s room and saw the altercation. Ms. Ruck observed that Mr. Polley was closer to the door of the room than E.C. was, and could have avoided the situation, left the room, or de-escalated the situation before he hit the patient.

10. That same morning, during the hospital's investigation of the incident, Mr. Polley asked to speak to the hospital's chief executive officer, John Swent. He told Mr. Swent that he (Mr. Polley) could "really have hurt the patient if he [had] hit [the patient] with his right fist, but instead hit [the patient] with his left fist."[11] Mr. Polley said that his left wrist was sore and that an ER doctor had ordered an x-ray.[12]

11. The hospital dismissed Mr. Polley from its employment as a result of the altercation, and in March 2012 submitted a complaint report to the Board.

Conclusions of Law

We have jurisdiction. §§ 335.066 and 621.045, RSMo.[13]

The Board bears the burden of proving that cause exists to discipline Mr. Polley's license, which it must do by a preponderance of the evidence. *State Bd. of Nursing v. Berry*, 32 S.W.3d 638, 642 (Mo. App. W.D. 2000). A preponderance of the evidence is evidence showing, as a whole, that "the fact to be proved [is] more probable than not." *Id.* This Commission judges witness credibility and may believe all, part or none of a witness' testimony. *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo. App. W.D. 1992).

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[10] Tr. 26, Testimony of Kenneth Polley.

[11] Petitioner's Exhibit A, p. 20 (""Exhibit 1, page 5").

[12] *Id*.

[13] References to "RSMo" are to the Revised Statutes of Missouri (2012 Supp.), unless otherwise noted.

Here, the Board argues cause for discipline exists under § 335.066.2 (5) and (12), which state in relevant part:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
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> (5) Incompetency [or] misconduct...in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096; [and]
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> ***
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> (12) Violation of any professional trust or confidence[.]

We agree with the Board.

Subdivision (5) – incompetency and misconduct

Under subdivision (5), the Board points to incompetency and misconduct as grounds for discipline. "Incompetency" is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability. *Albanna v. State Bd. of Regis. for Healing Arts*, 293 S.W.3d 423, 435 (Mo. banc 2009). Incompetency is not necessarily established by a negligent act, or even a series of negligent acts, but by demonstration that the professional is unable or unwilling to function properly. *Id.* at 436 (c*iting Tendai v. State Bd. of Regis. for Healing Arts*, 161 S.W.3d 358, 369 (Mo. banc 2005)).

In the context of professional licensure and discipline, Missouri courts define "misconduct" as "the willful doing of an act with a wrongful intention." *See Duncan v. Mo. Bd. for Architects, Professional Engineers and Land Surveyors*, 744 S.W.2d 524, 541 (Mo. App. E.D. 1988).

Mr. Polley displayed incompetency in dealing with E.C. Licensed practical nurses care for and assist their patients, including patients who are in pain and irritable or on the verge of losing control, by using "substantial specialized skill, judgment, and knowledge." § 335.016(14), RSMo. Mr. Polley appeared generally to have sufficient professional ability, but with regard to E.C., displayed lack of any disposition to use it, and displayed that he was unable or unwilling to function properly, as discussed immediately below.

E.C. had had a cardiac procedure a week before his visit to the Iron County Hospital emergency room. He was having chest pain despite having already had nitroglycerin and morphine that night and was short-tempered. What happened the first time Mr. Polley went into E.C.'s room was sufficient to put Mr. Polley on notice that the patient was irritable and on the verge of losing control: The patient cursed at Mr. Polley and told him to leave, which Mr. Polley promptly did, even though it meant the patient did not receive the medication the doctor had ordered.

Later, when Ms. Kure asked Mr. Polley to run an EKG strip on E.C., she had to ask him twice. Neither time did Mr. Polley explain any concern he had in returning to the room and attempting to perform the test. Rather, he seemed to view the request as an opportunity to confront the patient. After Ms. Kure asked him the second time, Mr. Polley said, "[A]re you asking me to go get it [that is, run the strip]?"[14] According to Mr. Polley, she said yes, "[s]o [he] went in to get it."[15]

When he went into the room, the patient was sitting up in bed and was still angry. The patient said, "You need to get the fuck out of here."[16] A nurse who was disposed to use his sufficient professional ability, and who was able and willing to function properly, would have left

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[14] Tr. 22.

[15] *Id*.

[16] *Id*. at 26.

the room, or attempted to reason with the patient, or de-escalate the situation while he had the opportunity. But Mr. Polley did not leave as he had the first time, even though he was located closer to the door than E.C. and could easily have done so. Mr. Polley did not explain to E.C. what he (Mr. Polley) needed to do or why, even though Ms. Kure had just explained to Mr. Polley that E.C. could not be transferred to the other hospital (where E.C. wanted to go) without the E.K.G. strip. And Mr. Polley did not otherwise attempt to de-escalate the situation, even though he had the opportunity at that time.

Instead, Mr. Polley fanned the flames. He ignored E.C.'s demand and demeanor, and what he knew about E.C. already, looked over his shoulder at E.C., and said, "I have a job to do, sir."[17] A blow-up ensued, somewhat predictably in view of all the circumstances, and the patient was injured by Mr. Polley. Mr. Polley displayed incompetency.

Mr. Polley claimed at hearing that he punched the patient in self defense. As the foregoing discussion demonstrates, our conclusion regarding incompetency does not rest on the fact of the punch alone. Ample other evidence supports it. In any event, Mr. Polley's punch was an exaggerated response to the situation.

Mr. Polley is a former police officer and Marine, and as a result has presumably had training in and experience with self-defense, de-escalation techniques, and hand-to-hand fighting. Although E.C. apparently had some advantage on Mr. Polley in size,[18] the punch Mr. Polley delivered was a fairly devastating one. Mr. Polley in fact had time to calculate what he intended to accomplish with the punch, in that he chose to deliver it with his non-dominant hand, as he

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[17] *Id.*

[18] The sheriff's report prepared after the altercation describes E.C. as 6' tall and 240 pounds, and Mr. Polley as 5'8" tall and 200 pounds. Petitioner's Exhibit A, p. 26 (""Exhibit 5, page 2"). Mr. Polley exaggerated the difference at hearing, describing E.C. as about 6'4" tall and 250 pounds, and himself as 5'7" tall and 170 pounds. Tr. 26.

explained to the hospital's CEO the morning of the incident. He then put E.C. in some kind of position of restraint, which we gather was successful.

Mr. Polley also testified at hearing that the patient's I.V. line became completely wrapped around his (Mr. Polley's) neck during the altercation.[19] But a witness to the incident, a certified nurse assistant, testified that she never saw the line around Mr. Polley's neck.[20] We find the witness credible and disbelieve Mr. Polley's description.

The same witness also testified that Mr. Polley could have avoided the situation by leaving, or de-escalated the situation, before he hit the patient.[21]

In short, Mr. Polley was capable of controlling the situation without punching E.C. in the face. Even if Mr. Polley was alarmed by E.C.'s quick reaction to Mr. Polley's remark that he (Mr. Polley) had a job to do and failure to explain what that job was, we cannot conclude that his alarm excuses the punch for purposes of our analysis under § 335.066.2(5), inasmuch as Mr. Polley was the trigger for that quick reaction.

Additionally, we conclude Mr. Polley engaged in misconduct for purposes of § 335.066.2(5), which we earlier explained is the willful doing of an act with a wrongful intention. Patients who are irritable and on the verge of losing control, whether because they are in pain or frightened, or for some other reason, should be cared for and assisted by their nurse, and not further irritated or provoked. Mr. Polley did not care for or assist the patient. He instead further irritated or provoked E.C., and ultimately, consciously injured him. Such behavior is misconduct.

We find cause to discipline Mr. Polley's license under § 335.066.2(5) based on incompetency and misconduct.

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19 Tr. 27.

20 Tr. 19-20, Testimony of Allison Ruck.

21 *Id.* at 18.

Subdivision (12) – Professional Trust or Confidence

The Board also points to § 335.066.2(12) as grounds for discipline, violation of professional trust or confidence. We conclude the Board has established such cause by a preponderance of the evidence.

The phrase "professional trust or confidence" is not defined in Chapter 335. Absent a statutory definition, the plain meaning of words used in a statute, as found in the dictionary, is typically relied on. *E&B Granite, Inc. v. Director of Revenue,* 331 S.W.3d 314, 318 (Mo. banc 2011). The dictionary definition of "professional" is

> of, relating to, or characteristic of a profession or calling…[;]… engaged in one of the learned professions or in an occupation requiring a high level of training and proficiency…[; and]…characterized or conforming to the technical or ethical standards of a profession or an occupation….

WEBSTER'S THIRD NEW INT'L DICTIONARY UNABRIDGED 1811 (1986). "Trust" is

> assured reliance on some person or thing [;] a confident dependence on the character, ability, strength, or truth of someone or something…[.]

Id. at 2456. "Confidence" is a synonym for "trust." *Id.* at 475 and 2456. Trust "implies an assured attitude toward another which may rest on blended evidence of experience and more subjective grounds such as knowledge, affection, admiration, respect, or reverence[.]" *Id.* at 2456. Confidence "may indicate a feeling of sureness about another that is based on experience and evidence without strong effect of the subjective[.]" *Id.* Therefore, professional trust or confidence means reliance on the special knowledge and skills evidenced by professional licensure.

As noted above, LPNs promote health, and care for persons who are "ill, injured, or experiencing alterations in normal health processes[,]" using "substantial specialized skill, judgment, and knowledge." § 335.016(14). They provide such nursing care under the direction

of physicians or other persons licensed to prescribe medications and treatments, or registered professional nurses. *Id.*

Mr. Polley violated the professional trust and confidence of a patient. He did not care for E.C. using skill, judgment and knowledge, whether by explaining to E.C. what was happening, or de-escalating the situation, or acceding to E.C.'s wishes not to be treated by him. Instead, he acted deliberately to seriously injure E.C.

Mr. Polley also violated the professional trust and confidence of those with whom he worked, in failing to discuss with the nurse who was also caring for E.C. any concern he had about running the E.K.G. on E.C., and triggering the altercation in a busy hospital emergency department.

We note that the hospital's policies included certain patient rights regarding treatment at the hospital, including the right to refuse medication or to be cared for by a particular nurse, and that the policies forbid a nurse to assault a patient.[22] Mr. Polley denied being familiar with hospital policies about minimizing violence, and denied having even read hospital policies prior to the incident.[23] Assuming for the sake of argument that Mr. Polley was not familiar with the policies, and even if they did not exist at all, an LPN owes professional trust and confidence to his patients and coworkers as discussed above, and Mr. Polley violated that responsibility.

Cause for discipline exists under § 335.066.2(12).

[22] Tr. 12, Testimony of Sheila Kure.

[23] Tr. 23, Testimony of Kenneth Polley.

Summary

Cause exists to discipline Mr. Polley's practical nurse license under §335.066.2(5) and (12), for the reasons discussed above.

SO ORDERED on January 10, 2014.

\s\ Alana M. Barragán-Scott
ALANA M. BARRAGÁN-SCOTT
Commissioner